GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 6, 2024

Jamie Beson
Close To Home Assisted Living Riegel II, LLC
1805 Raymond Street
Bay City, MI 48706

RE: License #:	AL090382071
Investigation #:	2024A0123018
	Close To Home Assisted Living Riegel II

Dear Jamie Beson:

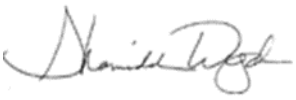
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL090382071
Investigation #:	2024A0123018
Complaint Receipt Date:	01/29/2024
Investigation Initiation Date:	01/31/2024
Report Due Date:	03/29/2024
Licensee Name:	Close To Home Assisted Living Riegel II, LLC
Licensee Address:	1805 Raymond Street Bay City, MI 48706
Licensee Telephone #:	(989) 778-2575
Administrator:	Jamie Beson
Licensee Designee:	Jamie Beson
Name of Facility:	Close To Home Assisted Living Riegel II
Facility Address:	1805 Raymond Street Bay City, MI 48706
Facility Telephone #:	(989) 778-2575
Original Issuance Date:	03/23/2017
License Status:	REGULAR
Effective Date:	09/23/2023
Expiration Date:	09/22/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A pushed Resident B on 01/22/24. Resident A does not allow anyone in his bedroom, including his physician.	No
Resident A passed out Advil to Resident D, and Resident D gave the pills to staff. Resident A cannot manage his medications.	No
Staff allowed Resident A to go to the store. Resident A purchased Advil over the counter, was supposed to give it to staff, but didn't.	Yes
Additional Findings	No

III. METHODOLOGY

01/29/2024	Special Investigation Intake 2024A0123018
01/29/2024	APS Referral Information received regarding APS referral.
01/31/2024	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
02/01/2024	Contact - Telephone call made I spoke with licensee designee Jamie Beson.
02/05/2024	Contact - Document Received Requested documentation received via fax.
02/13/2024	Contact - Document Received Requested documentation received.
02/27/2024	Contact- Telephone call made I made a call to Resident A’s Region 7 waiver nurse Diana Mersmann.
02/27/2024	Contact- Document Received I received requested documentation via email.
03/06/2024	Exit Conference I spoke with licensee designee Jamie Beson.

ALLEGATION:

- **Resident A pushed Resident B on 01/22/24. Resident A does not allow anyone in his bedroom, including his physician.**

- **Resident A passed out Advil to Resident D, and Resident D gave the pills to staff. Resident A cannot manage his medications.**

- **Staff allowed Resident A to go to the store. Resident A purchased Advil over the counter, was supposed to give it to staff, but didn't.**

INVESTIGATION: On 01/31/2024, I spoke with home manager Debbie Morgan and staff Stephanie Reid. Staff Morgan stated that Resident A purchased Advil for himself. Resident A denied having Advil in his possession, and multiple staff attempted to retrieve the medication. Resident A gave four pills to Resident D, who then told staff about it. Resident A received a 30-day discharge notice on 01/22/2024. Staff Morgan stated that about 37 pills out of 180 were missing. The Advil was purchased on 01/20, and staff were able to get the medication from Resident A on 01/29/2024. Staff Morgan stated that Resident A joined Resident C, and Resident C's relative on a trip to Walmart, and this is how Resident A obtained the Advil. Staff Morgan stated that Resident B, who lives in the adjacent facility, was standing in the doorway hugging another resident. It was reported that Resident A pushed Resident B and ran over the resident's toe with his wheelchair. Staff Morgan stated that it happened outside her office, and she responded to the incident immediately after hearing the commotion. Staff Reid stated that she is the med passer, and Resident A's Relative 1 gave the remaining Advil to Staff Morgan, who then gave it to Staff Reid.

On 01/31/2024, I conducted an unannounced on-site at the facility. I interviewed Resident A. Resident A admitted to purchasing over the counter Advil. Resident A denied having a letter from a physician that allows Resident A to self-dispense medication. Resident A denied currently possessing any medication. Resident A admitted to giving four Advil pills to Resident D who Resident A said was in pain. Resident A reported self-administering two Advil every six hours as needed. Resident A reported taking eight Advil out of the bottle, then gave the remainder to a relative. Resident A reported refusing to let certain staff in Resident A's room and stated that it is a matter of trust. Resident A reported receiving a 30-day notice, and Region 7 is helping Resident A find another placement. Resident A denied being mean to other people. Resident A stated that there were two residents standing in the doorway hugging, and Resident A asked one to move twice. Resident A reported pushing Resident B's shoulder sideways then let Resident B go.

On 02/01/2024, I spoke with licensee designee Jamie Beson via phone. Jamie Beson stated that staff found out that Resident A had the Advil on 01/21/2024. Resident A did not admit having the Advil until Resident A was interviewed by Adult Protective Services. Resident A also admitted to handing the medication out to

Resident D. On 01/29/2024, Resident A's Relative 1 came to visit, and Resident A handed over the Advil bottle to Relative 1 who gave them to staff. Prior to this, staff had searched Resident A's room but could not find the medication. A call was placed to the Resident C's relative, who gave Resident A a ride to the store where Resident A purchased the medication. Resident C's relative verified that the purchase was made. Resident A received a 30-day notice on 01/22/2024 due to passing out the Advil, and too many issues with non-compliance. Resident A does not have consent from a physician to self-administer medication but does have a script for Advil. Resident A has been refusing care and refused two doctor's visits. Resident A's physician threatened to discharge Resident A as a patient. Resident A refuses to let staff clean Resident A's room, and Resident A will barricade the door so they cannot enter. Resident A may have run over a resident's foot by accident. The incident happened right outside the manager's office. Jamie Beson stated that she does not believe Resident A pushed the other resident, but laid hands on her to move her out of the way.

On 02/05/2024, I received copies of requested documents via fax. A copy of Resident A's electronic medication administration records for January 2024 was received. It has Advil 200 mg liqui-gel capsule listed as a PRN. Staff administered this medication on January 1st thru January 4th, 2024, and January 29th thru January 31st. The physician order for the medication notes that Resident A can "*Take two capsules by mouth every six hours as needed ***Patient Provides****".

Resident A's *Assessment Plan for AFC Residents* dated 08/2/2023 signed by Resident A and licensee designee Jamie Beson states that "*Close To Home staff to administer all medications.*" For "*Moves Independently In Community*", the yes box is checked, but in the description box it states, "*[Resident A] will need someone with [Resident A] to go off property."* The assessment plan notes that Resident A controls aggressive behaviors, gets along with others, and for following instructions it states *"[Resident A] is willing to do what [Resident A] is asked if it is something [Resident A] agrees with."* Per Resident A's records, Resident A moved into the facility on 08/02/2023.

On 02/13/2024, I requested and received a photo of the Advil bottle that Resident A purchased. The bottle is a 180 count Advil Liqui-Gels that is 200 mg.

A copy of Resident A's 30-day notice was received as well. It states that Resident A is receiving the 30-day notice due to Resident A buying Advil, not turning it over to staff, passing the Advil out to others, and refusing to turn over the medication to staff. The 30-day notice is dated 01/22/2024.

A copy of an *AFC Licensing Division- Incident/Accident Report* was also received. The incident report is dated 01/21/2024. It states the following:

"[Resident E] reported to floor staff, [Resident A] purchased Advil at the store and had reason to believe [Resident A] had given some to another resident."

“Staff questioned [Resident A] if [Resident A] had purchased Advil and if [Resident A] gave any to [Resident D]. [Resident A] denied both. Staff questioned [Resident D] who confirmed [Resident A] gave [Resident D] 4 Advil. [Resident D] returned 2 Advil to staff but report reported [Resident D] took the other 2. Staff spoke with [Resident A] again who continued to deny having any Advil.”

“*Management spoke with [Resident A] who continued to deny any wrongdoing and would not turn over Advil. CTH issued [Resident A] a 30-day notice for having medication in [Resident A’s] room and giving it to other residents. Management had staff search room could not find Advil. Resident’s family was able to get [Resident A] to turn over Advil*.”

On 02/27/2024, I made a call to Region 7 Waiver. I spoke with supports coordinator Diana Mersmann, RN. She stated that she does not think that Resident A is capable of being in the community without staff supervision. For safety reasons, Resident A should go out with staff, and she stated she does not understand why a visitor would agree with taking Resident A out in the community. Resident A is moderately impaired and has memory problems (i.e. short term, procedural, and situational memory issues). Resident A makes impulsive and poor decisions. Resident A is not nice to people and is intimidating. Staff have to watch Resident A so Resident A does not hurt anyone. Resident A’s verbal aggression has been a big issue. Nurse Mersmann stated that Resident A did admit to her about the Advil. Resident A eventually turned the medications over after Relative 1 convinced Resident A to do so. Nurse Mersmann stated that she has no concerns with how the facility handled the situation with the Advil. Staff tried to get the medication from Resident A, and also notified all parties about the incident.

On 02/27/2024, I received a copy of Resident A’s *Region VII Area Agency on Aging Compass Assessment Report* dated 10/24/2023 authored by supports coordinator Diana Mersmann, RN. On page seven of the assessment report, it states that Resident A has a memory problem for short-term memory, procedural memory, and situational memory. It notes on page nine, that staff at the facility reported that Resident A has behaviors that are disruptive, including swearing at staff, locking his door constantly, needing to be redirected often, resisting care, and being impulsive. On page 14, under Section P: Physical Functioning, it notes under the category of “*Shopping: Performance”* and “*Shopping: Capacity* “*Total dependence- Full performance by others during entire period*.” The assessment report notes on page 16 that Resident A is pivot transfer only, “*needs cuing and reminders at times due to memory problems related to a past traumatic brain injury*.” It also notes that staff have to monitor Resident A because Resident A gets irritated with other residents, and Resident A’s behavior includes making negative inappropriate statements, swearing, and arguing. On page 19 of the assessment report, it notes that Resident A’s *Service Need Level* is a *2c*. It states “*2C This means you can be left alone for a short time. Staff at your place of residence must be available to you periodically each day*.”

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	An unannounced on-site was conducted on 01/31/2024. Resident A was interviewed and reported only pushing Resident B's shoulder sideways then let the resident go. Resident A stated that due to trust reasons, Resident A does not let certain staff Resident A's bedroom. Resident A reported receiving a 30-day notice. Home manager Debbie Morgan stated that she overhead the incident between Resident A and Resident B but did not witness it. Staff Morgan reported Resident A received a 30-day discharge notice. Resident A's *Assessment Plan for AFC Residents* dated 08/2/2023, the day Resident A moved in at the time stated that Resident A controls aggressive behaviors, gets along with others, and for following instructions it states *"[Resident A] is willing to do what he is asked if it is something he agrees with."* On 02/01/2024, Jamie Beson was interviewed and reported Resident A may have run over Resident B's foot by accident and does not believe Resident A pushed Resident B. Jamie Beson stated that Resident A received a 30-day notice due to non-compliance issues. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	An unannounced on-site was conducted on 01/31/2024. Resident A was interviewed and admitted to purchasing Advil, and not having doctor's permission to self-administer medication. Resident A stated reported turning the medication over to Relative 1. Staff Debbie Morgan was interviewed and stated that Resident A denied having any Advil initially, but staff were able to get the medication on 01/29/2024 after being alerted about it, and after several attempts at staff trying to locate the medication. On 02/01/2024, Licensee Designee Jamie Beson was interviewed and stated that Resident A did not admit to having any Advil, and Resident A did not have physician written consent to administer his own medicine. She stated that a 30-day notice was issued for non-compliance. An *AFC Licensing Division- Incident/Accident Report* dated 01/21/2024 details how staff were notified that Resident A had the medication. Resident A denied to staff of being in possession of any medication. A 30-day discharge notice was issued. There was no preponderance of evidence to substantiate a rule violation as staff were not initially aware Resident A was in possession of the medication and made attempts to retrieve the medications after being informed about it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the

	medication was prescribed.
ANALYSIS:	An unannounced on-site was conducted on 01/31/2024. Resident A was interviewed and admitted to giving Resident D four Advil. An *AFC Licensing Division- Incident/Accident Report* dated 01/21/2024 states Resident E told staff Resident A bought Advil and may have given some to Resident D. At that time Resident A denied both buying the Advil and giving Resident D some pills. Resident D confirmed being provided four of the pills by Resident A, and Resident D returned two of the pills to staff. The facility issued Resident A a 30-day discharge notice for having medication in his room, and giving it to Resident D. There was no preponderance of evidence to substantiate a rule violation as staff were not initially aware Resident A was in possession of the medication and made attempts to retrieve the medications after being informed about it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

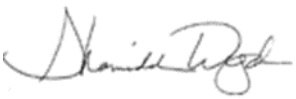
APPLICABLE RULE	
R400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 01/31/2024, I conducted an unannounced on-site at the facility. Resident A admitted going to the store and buying Advil. Staff Debbie Morgan and licensee designee Jamie Beson stated that Resident A got a ride to the store with Resident C's relative. On 02/27/2024, I received a copy of Resident A's *Region VII Area Agency on Aging Compass Assessment Report* dated 10/24/2023 authored by supports coordinator Diana Mersmann, RN. The assessment indicates Resident A is total dependence in the area of shopping, and that Resident A can only be left alone for a short period of time. Resident A's *Assessment Plan for AFC Residents* dated

	08/23/2023 was reviewed. For "*Moves Independently In Community*", the yes box is checked, but in the description box it states, "*He will need someone with him to go off property."* There is a preponderance of evidence to substantiate a rule violation. Resident A left the premises of the home without appropriate supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/06/2024, I conducted an exit conference with licensee designee Jamie Beson. Jamie Beson was informed of the findings and conclusions.

IV. RECOMMENDATION

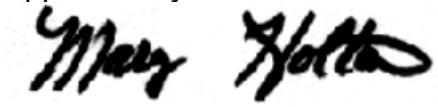
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).



03/06/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



03/06/2024

Mary E. Holton Date
Area Manager